

<b>Case Number:</b>	CM15-0042203		
<b>Date Assigned:</b>	03/12/2015	<b>Date of Injury:</b>	12/15/2004
<b>Decision Date:</b>	04/22/2015	<b>UR Denial Date:</b>	02/19/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/05/2015

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: New Jersey, Michigan, California  
 Certification(s)/Specialty: Neurology, Neuromuscular Medicine

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 64 year old female who sustained an industrial injury on December 15, 2004. She has reported injury to the lower back and has been diagnosed with lumbar degenerative disc disease, right shoulder bursitis/tendinitis, impingement syndrome, cervical degenerative disc disease, partial thickness rotator cuff tear, status post right total hip replacement for advanced osteoarthritis, right knee pain, and probable left shoulder impingement syndrome. Treatment has included Ice, massage, TENS unit, and medications. Currently the injured worker complains of neck, right shoulder, right wrist, low back, right hip, and right knee pain. The treatment plan included lidocaine gel.

### IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

**One tube of ointment 5%:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm (lidocaine patch) Page(s): 56.

**Decision rationale:** According to MTUS guidelines, "Lidoderm is the brand name for a lidocaine patch produced by Endo Pharmaceuticals. Topical lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin." In this case, there is no documentation that the patient developed neuropathic pain that did not respond to first line therapy and the need for Lidocaine gel is unclear. There is no documentation of efficacy of previous use of Lidocaine gel. Therefore, the prescription of Lidocaine gel is not medically necessary.